Adult Care Home Challenges – An Industry Perspective

Blue Ribbon Commission
Transition to the Community Subcommittee

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Description of Adult Care Home Populations

- Frail elderly
- Individuals with chronic illnesses (diabetes, heart disease, respiratory ailments, mental health problems, and intellectual developmental disabilities (IDD)
- Individuals unable to remain in private living arrangement but do not meet the medical criteria for admission to SNF
- Individuals who require supervision and assistance with medications
- Individuals unable to perform activities of daily living
- Individuals with Alzheimer's disease and other forms of dementia

Description of Adult Care Home Populations

Demographic Information*:

- Female 60% Male 40%
- Average age – 70
- Age distribution:
  - Under age 40 – 6%
  - Age 40 - 54 – 13%
  - Age 55 – 64 – 17%
  - Age 65 – 74 – 20%
  - Age 75 – 84 – 22%
  - Age 85+ - 22%

**Demographic information obtained from NCALTCF and a LTC Pharmacy. Information is not from a valid statistical sample and is likely to vary from actual assessment data obtained by DMA.*

Description of Adult Care Home Populations

Demographic Information, Continued

- Types of Diagnoses:
  - 85% - Chronic Medical Condition
  - 40% - Physical Disability
  - 40% - Dementia
  - 35% - Mental Illness
  - 15% - Intellectual Developmental Disability

Description of Adult Care Home Populations

Demographic Information, Continued

- Resident Risk Issues
  - 98% - 24 hr. caregiver availability required to ensure patient safety
  - 95% - Adverse consequences of medications non-compliance
  - 70% - Falls
  - 60% - Malnutrition
  - 45% - Skin Breakdown

Description of Adult Care Home Populations

Demographic Information, Continued

- Medications:
  - 12 – Average number of medications per resident
  - 20 – Average number of daily doses
- Special Monitoring:
  - 50% - Blood pressure monitoring
  - 30% - Blood glucose monitoring
- Special Diets – 60%

Description of Adult Care Home Populations

Demographic Information, Continued

- Residents qualified for new PCS criteria – 54%
- Number of hours per month per resident – 66

Description of Adult Care Home Funding Sources

There are two public programs that provide funding for ACHs

- Special Assistance – state income supplement program used to pay for room and board for ACH residents
  - Current SA rate = $1,182 mo.
- Medicaid – optional state plan service that reimburses for personal care services
  - Current PCS rate = $18.21 daily per diem
- Medicaid SCU-PCS – optional state plan service that reimburses for Alzheimer's related care
  - Current SCU-PCS = $48.68 daily per diem

Description of Adult Care Home Funding Sources

Special Assistance covers room and board – which includes:

- Property ownership and use
- Operation and maintenance of plant
- Housekeeping and Laundry services
- Dietary services
- Recreation activities
- General Administration

Description of Adult Care Home Funding Sources

Personal Care Service reimbursement covers:

- Direct care aides and supervisors –wages and related payroll costs.

- Currently the SA and PCS reimbursements do NOT cover the costs related to the employment of Medication Aides.

Description of Adult Care Home Funding Sources

SA-ACH vs. SA-In Home

- Building sanitation inspections every six months
- Kitchen sanitation inspections every three months
- NC DHSR building bi-annual inspection
- Local Fire Marshall inspections
- Local Building code inspections
- OSHA

Impact of Requirements from US Department of Justice

- In-Reach Program – has potential to become harassment due to frequency requirements and lack of acknowledgement that residents may choose to reside in ACHs
- Mandates MH services to be provided by NC – ACH residents will be allowed to receive services
- Housing slots will allow ACH residents the choice of community housing – how will least restrictive setting be determined? How will most appropriate setting be determined?

Impact of Requirements from IMD Determinations

Institution for mental diseases is defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its **overall character** as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD."

Impact of Requirements from IMD Determinations

Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

Impact of Requirements from IMD Determinations

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;

3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);

4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

Impact of Requirements from IMD Determinations

- Because of limited housing alternatives, IMD confirmed residents from IMD confirmed ACHs will be shuffled from one ACH to another ACH. Creating a cycle that has the ability to become a repetitive cycle.
- It may be possible with the first 25 facilities to identify alternative placements, but as this process continues and ACHs become more aware of the risk, finding alternative placements will become more difficult.

Impact of Requirements from IMD Determinations

- The IMD determination process is inherently subjective. As evidenced by the final decision being made by individuals from DMA/DHHS sitting around a conference room table.
- Yet, DMA plans to ask individual ACHs to sign an attestation (probably annually) that the ACH is in compliance with IMD rules.

Impact of Requirements from PCS Changes

- Potentially significant percentage (46%) of ACH residents will not qualify for new PCS model. As many as 9,000 residents.
- Residents who suffer chronic medical conditions but are ADL independent could be left without housing or services.
- Remember – If a resident doesn't qualify for services in an ACH then they don't qualify for services in the community.
- ACH providers will be forced into bankruptcy. Residents will be homeless. Unemployment will increase.

Possible Solutions

- NC should consider a written policy specific to NC that defines "least restrictive setting." The policy should include an assessment of what is the most appropriate setting for each individual.
- There needs to some type of acuity-based reimbursement system. If not, individuals with the lowest needs will end up in the most expensive service settings. Conversely, residents with some of the greatest needs will end up remaining in ACHs.

Possible Solutions

- We need alternative funding streams that are not ADL driven to serve the individuals residing in ACHs who do not need ADL assistance but do require ACH level of care.
- Secure the I-Option for ACH-SCUs.
- Explore adding Fair Rental Value type incentive program to encourage providers to reinvest in the physical plant.
- Allow ACH beds approved under CON rules to provide alternative housing options – such as 16-bed conversions for MH services.